Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-06-7037-01

MFDR Date Received
JULY 12, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated July 11, 2006: "Memorial Hermann Hospital System ('MHHS') submitted its UB92 and itemized statement reflecting ICD-9 code 800.0. Pursuant to TWCC Rule 134.401(c)(5) (tauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which is $58,765.75. Texas Mutual issued an underpayment of $5,977.27 and denying any balance owed on the basis that the billed charges did not meet the stop-loss method of acute care and the claim was reimbursed at the fair and reasonable charge. However, this claim does not involve the stop-loss method of reimbursement because it is trauma. Therefore, additional reimbursement of $52,788.48 is due and owing to the hospital."

Requestor's Supplemental Position Summary dated August 28, 2006: "It is the hospital's position that the that the patient required unusually extensive medical treatment to resolve his complicated medical condition. Because there is no certainty or predictability as to what a patient's needs will be in any given trauma admit, the cost of providing necessary care and treatment cannot be predicted with any degree of certainty. Memorial Hermann Hospital is one of only two Level 1 trauma facilities in the Houston, Harris County area and well-known and held with high regard for its critical care treatment. The carrier issued an underpayment of $8,369.04 leaving additional reimbursement due of $50,396.71."

Requestor's Supplemental Position Summary dated December 12, 2011: "Enclosed please find the Curriculum Vitae and Affidavit of Patricia L. Metzger, Chief of Care Management for Memorial Hermann. Ms. Metzger has extensive knowledge of medical care, treatment plans, and inherently complicated surgical procedures which would require extensive services and supplies by hospital providers. With respect to this case, Ms. Metzger unequivocally states that the medical services and supplies provided to the patient were complicated and extensive."

Amount in Dispute: $50,396.71*

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...It appears the requestor is requesting to receive reimbursement based on a percentage of charges or paid in full. It is this carrier's position that reimbursement based on a percentage or paid in full is not compliant with TWCC Rule Rule [sic] 134.401(c)(1)… Therefore, no additional reimbursement is due. The requestor has failed to provide any information to support the amount paid by Texas Mutual is NOT fair or reasonable. The requestor, on the other hand, has failed to submit any information to support its billing of $58,765.75 is either fair or reasonable for the service provided."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2005 through July 26, 2005	Inpatient Services	$50,396.71*	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Billed charges do not meet the Stop-loss method standard of the 08/01/97 Acute Care Inpatient Hospital Fee Guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay. Allowing 4 days surgical per diem at $1118/day as fair and reasonable.
   - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 480 – Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - 719 – Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data is submitted.
   - 730 – Denied as included in per diem rate.
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - CAC-18 – Duplicate claim/service.
   - 878 – Duplicate appeal. Request Medical Dispute Resolution through DWC for continued disagreement of original appeal decision.
   - 920 – Reimbursement is being allowed based upon a dispute.

Findings

1. * The respondent submitted an explanation of benefits, dated July 28, 2006, showing an additional payment in the amount of $2,391.77 was made to the requestor. The requestor has states in their supplemental response dated August 28, 2006 that the carrier issued an underpayment of $8,369.04 leaving additional reimbursement due of $50,396.71.
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the

entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 800.00. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

3. Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective January 1, 2003, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor seeks full reimbursement of billed charges based upon "Texas Mutual issued an underpayment of $5,977.27 and denying any balance owed on the basis that the billed charges did not meet the stop-loss method of acute care and the claim was reimbursed at the fair and reasonable charge. However, this claim does not involve the stop-loss method of reimbursement because it is trauma. Therefore, additional reimbursement of $52,788.48 is due and owing to the hospital."
   - The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		November 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		November 28, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.